



September 11th
Victim Compensation Fund

OMB 1105-0092

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Decedent's SSN or National ID Number

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Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund Exhibit A to the Eligibility Form For Deceased Individuals Authorization for Release of Medical Records

Instructions for Personal Representative - Please list all doctors and health care providers who were involved in diagnosing and treating the Decedent's injury, as well as any other entities (e.g., insurance companies, workers' compensation programs, pension programs) that may have medical information in Section 1. Please copy this exhibit and complete if you need to list more than one health care provider or other entities. Then, please print your name and address and sign in the block in Section 2.

When you sign this document, you give permission to the Decedent's doctors, health care providers or other entities listed below to disclose the Decedent's health information to the September 11th Victim Compensation Fund (VCF), the United States Department of Justice (DOJ), and the World Trade Center (WTC) Health Program administered by the National Institute for Occupational Safety and Health (NIOSH)¹ for purposes of evaluating your claim for compensation to the VCF. By signing this document, you also give permission to the VCF to disclose the Decedent's health information to the WTC Health Program and to the WTC Health Program to disclose the Decedent's health information to the VCF for the purpose of evaluating your claim for compensation under the VCF.

Please note that you may revoke this Authorization at any time, except to the extent that VCF, WTC Health Program, or the providers listed below have already acted based on this Authorization. To revoke this authorization, you must write to the providers or entities listed below and to the VCF at the address at the bottom of page 3 of this form.² This authorization is valid for six (6) years from the date signed or upon your written termination, whichever is sooner.

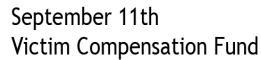
The Decedent's providers and certain other entities are required by the Privacy Rule under HIPAA to protect the Decedent's health information. When they provide the information to the VCF it will not be protected by this same Privacy Rule. However, the VCF and DOJ will continue to protect the confidentiality of the Decedent's medical records to the extent they are permitted to do so under another Federal law, the Privacy Act.³ The VCF will not disclose the Decedent's identifiable health information that it receives under this Authorization without your written consent except where authorized to do so by law.

Information to be disclosed by the Decedent's health care providers (or other entities listed below) to the Victim Compensation Fund includes, but is not limited to, application or enrollment information, eligibility information, claims records, claim status, pension records and files, entire patient medical records, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to the Decedent's doctors and medical care providers by other health care providers. The Decedent's health care providers and/or the VCF may also disclose this information to the WTC Health Program for the purpose of evaluating your claim for benefits under the VCF. In addition, the WTC Health Program may disclose information to the VCF for purposes of evaluating the Decedent's VCF claim.

¹ For the purposes of this document, all references to the WTC Health Program also include NIOSH to the extent it administers the WTC Health Program, as well as all contractors and business associates of NIOSH who conduct activities on behalf of the WTC Health Program, including but not limited to the Clinical Centers of Excellence and Nationwide Provider Network.

² If you wish to revoke this authorization because you do not want the VCF and WTC Health Program to exchange the Decedent's health information for purposes of evaluating your claim for compensation under the VCF, then you only need to write to the VCF.

³ The WTC Health Program will protect the Decedent's health information pursuant to HIPAA and/or any other relevant laws and regulations.



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Decedent's SSN or National ID Number				
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Personal Representative's SSN or National ID Number				

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

**September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Deceased Individuals
Authorization for Release of Medical Records**

Section 2. - Decedent information

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Decedent's Last Name

[illegible]

First Name

[illegible]

Middle Name

[illegible]

Mailing Address

[illegible]

Mailing Address continued

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Apartment/Suite Number

[illegible]

City

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State/Province

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Zip/Postal Code

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Decedent's Social Security or National ID Number

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Decedent's Date of Birth (mm/dd/yyyy)

Section 3. - Personal Representative Information and Signature

This information shall be sent to:

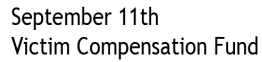
**September 11th Victim Compensation Fund
P.O. Box 34500
Washington, DC 20043**

I Certify that I am the person named below (Personal Representative making a claim to the Victim Compensation Fund on behalf of the Decedent) and I authorize the release of information listed above. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense subject to a \$5,000 fine.

$$\boxed{} \boxed{} / \boxed{} \boxed{} / \boxed{} \boxed{} \boxed{} \boxed{}$$

Date (mm/dd/yyyy)

Personal Representative Signature



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**September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Deceased Individuals
Authorization for Release of Medical Records**

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September 11th
Victim Compensation Fund

OMB 1105-0092

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Decedent's SSN or National ID Number

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Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit B1 to the Eligibility Form For Deceased Individuals
Authorization for Release of Pension Records and Health Information
by New York Individuals and Entities

Authorization for Release of Pension and Health Information from HIPAA and
Non-HIPAA Entities

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that pension and health information be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to my health provider, pension fund or other entity listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE OR PENSION INFORMATION WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**



September 11th
Victim Compensation Fund

OMB 1105-0092

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Decedent's SSN or National ID Number

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Personal Representative's SSN or National ID Number

**September 11th Victim Compensation Fund
Exhibit B1 to the Eligibility Form For Deceased Individuals
Authorization for Release of Pension Records and Health Information
by New York Individuals and Entities**

**Authorization for Release of Pension and Health Information from HIPAA and
Non-HIPAA Entities**

7. Name and address of health provider, pension fund, or other entity to release this information:
Please indicate all.

- ☒ New York Office of Payroll Administration (OPA)
Room 200N
One Centre Street
New York, NY 10007
- ☐ New York City Police Pension Fund (POLICE)
233 Broadway, 19th Floor
New York, NY 10279
- ☐ New York Fire Department Pension Fund (FIRE)
9 MetroTech Center
Brooklyn, NY 11201
- ☐ New York City Employees' Retirement System (NYCERS)
335 Adams Street, Suite 2300
Brooklyn, NY 11201-3724
- ☐ Teachers' Retirement System of the City of New York (TRS)
55 Water Street
New York, NY 10041
- ☐ New York City Board of Education Retirement System (BERS)
65 Court Street, 16th Floor
Brooklyn, NY 11201-4965

8. Name and address of person(s) or category of person to whom this information will be sent:

September 11th Victim Compensation Fund
P.O. Box 34500
Washington, DC 20043

Overnight deliveries can be made to:

September 11th Victim Compensation Fund
Claims Processing Center
1100 L Street N.W. - Suite 3000
Washington, DC 20005



September 11th
Victim Compensation Fund

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Decedent's SSN or National ID Number

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Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit B1 to the Eligibility Form For Deceased Individuals
Authorization for Release of Pension Records and Health Information
by New York Individuals and Entities

**Authorization for Release of Pension and Health Information from HIPAA and
Non-HIPAA Entities**

9(a). Specific information to be released:

- ☒ Complete Pension File, including, but not limited to:
Information regarding the type of pension awarded
(ADR, ODR or service), the amount, and whether or
not the benefit was awarded pursuant to the WTC
Disability Law.

Include: (*Indicate by Initialing*)

☐ Alcohol/Drug Treatment

☐ Mental Health Information

☐ HIV Related Information

Authorization to Discuss Health or Pension Information

- 9(b).** ☒ By initialing here
(Initials), I authorize

The individuals and entities identified in Question #7

(Name of individual health care provider, pension fund or other entity)

to discuss my health or pension-related information with my attorney, or a governmental agency,
listed here:

September 11th Victim Compensation Fund and the United States Department of Justice
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

- ☐ At request of individual
- ☒ Other: To evaluate my claim for
compensation with the September 11th
Victim Compensation Fund

**11. Date or event on which this authorization will
expire:**

Six (6) years from the date of signature or upon
my written termination

**12. If not the claimant, name of person signing
form:**

13. Authority to sign on behalf of claimant:

All items on this form have been completed and my questions about this form have been answered.
In addition, I have been provided a copy of the form.

Signature of claimant or representative authorized by law

Date: _____

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which
reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.



September 11th
Victim Compensation Fund

OMB 1105-0092

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Decedent's SSN or National ID Number

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Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit B2 to the Eligibility Form For Deceased Individuals
Authorization for Release of Health Information by New York Individuals and Entities

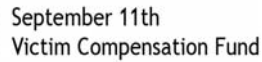
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**



The diagram shows three tens blocks and two units blocks, followed by a minus sign, then one ten block and two units blocks, followed by another minus sign, and finally two tens blocks. This represents the calculation $32 - 12 = 20$.



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Decedent's SSN or National ID Number

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Personal Representative's SSN or National ID Number

**September 11th Victim Compensation Fund
Exhibit B2 to the Eligibility Form For Deceased Individuals
Authorization for Release of Health Information by New York Individuals and Entities**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to insert (date) _____
- ☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

☐ Alcohol/Drug Treatment
☐ Mental Health Information
☐ HIV Related Information

Authorization to Discuss Health Information

9(b). ☐ By initialing here , I authorize
(Initials)

The individuals and entities identified in Question #7

(Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

the September 11th Victim Compensation Fund and the United States Department of Justice
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

- ☐ At request of individual
- ☒ Other: To evaluate my claim for compensation with the September 11th Victim Compensation Fund

11. Date or event on which this authorization will expire:

Six (6) years from the date of signature or upon my written termination.

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law

Date: _____

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

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Decedent's SSN or National ID Number				
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Personal Representative's SSN or National ID Number				

**September 11th Victim Compensation Fund
Exhibit C to the Eligibility Form For Deceased Individuals
Attorney Certification of Compliance with Provision on Limitation on Attorney Fees
(Section 104.81)**

If the Personal Representative has been represented by an attorney for services rendered in connection with this claim, **Personal Representative's attorney must complete the following certification:**

I hereby certify that:

- (1) The amount I have charged or will charge for the services I have rendered in connection with this claim, including expenses routinely incurred in the course of providing legal services, is not more than 10 percent of an award that might be paid on this claim; **AND**
- (2) I have not charged nor will I charge for any expenses incurred in connection with this claim that are not routinely incurred in the course of providing legal services, unless the Special Master has approved such expenses; **AND**
- (3) One of the following statements is true concerning a civil action brought by or on behalf of the Decedent for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001 or for damages arising from or related to debris removal (excluding civil actions to recover collateral source obligations or against any person who is a knowing participant in any conspiracy to hijack or commit any terrorist act) that was commenced after December 22, 2003 in which a release of all claims in such action was tendered prior to January 2, 2011:
- ☐ I did not charge a legal fee in connection with a settlement of this Decedent's claim(s) in such an action;
OR
 - ☐ I charged a legal fee in connection with a settlement of this Decedent's claim(s) in such an action that was 10 percent or more of the aggregate amount of compensation awarded through such settlement, and I have not charged nor will I charge for any services rendered in connection with this claim with the VCF;
OR
 - ☐ I charged a legal fee in connection with a settlement of this Decedent's claim(s) in such an action that was less than 10 percent of the aggregate amount of compensation awarded through such settlement, and the amount I have charged or will charge for the services I have rendered in connection with this claim with the VCF does not exceed the difference between 10 percent of such aggregate amount and the total amount of all legal fees I charged for services rendered in connection with such settlement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this

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 day of

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Signature of Attorney _____

[illegible]

Attorney's Name

[illegible]

Attorney's Firm/Address

[illegible]

Attorney's Firm/Address continued

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Suite

[illegible]

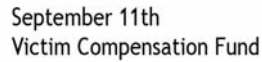
City

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State

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Zip/Postal code



The diagram shows three tens rods (each composed of ten units) minus two tens rods, resulting in one ten rod. This illustrates the calculation $30 - 20 = 10$.

The diagram shows three tens blocks and two units blocks, representing 32. Below them, one ten block and two units blocks are shown, representing 12. A minus sign is placed between the two groups. The result is two tens blocks, representing 20.

The diagram shows a 2x2 grid of squares, followed by a division symbol (/), then another 2x2 grid of squares, followed by another division symbol (/), and finally a 4x4 grid of squares. This illustrates the process of dividing a 2x2 grid by a 2x2 grid to produce a 4x4 grid.

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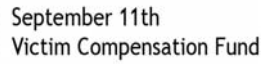
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**September 11th Victim Compensation Fund
Exhibit E to Eligibility Form For Deceased Individuals
Notice of Filing Claim**

- Fill out a separate copy of this page for each person to whom you are required to provide a Notice of Filing.
- On each copy, fill out the name and address of the person to whom you are providing the Notice and insert the name of the Decedent in the spaces provided below as indicated.
- Deliver each Notice personally or by certified mail, return receipt requested.
- *You must deliver a copy of this document to the following people:*
 - The immediate family of the Decedent (including, but not limited to, the spouse, former spouse(s), children other dependents, siblings, and parents)
 - The Executor or Administrator and beneficiaries of the Decedent's will and life insurance policies.
 - Any other person who may reasonably be expected to assert an interest in an award or to have a cause of action to recover damages relating to the wrongful death of the Decedent.

TO: NAME: _____

 ADDRESS: _____



**September 11th Victim Compensation Fund
Exhibit F - List of Individuals Notified of Claim Filing**

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Decedent's SSN or National ID Number OMB 1545-0047

Personal Representative's SSN or National ID Number

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Decedent's SSN or National ID Number OMB 1545-0047

Personal Representative's SSN or National ID Number

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Decedent's SSN or National ID Number OMB 1545-0047

Personal Representative's SSN or National ID Number

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Return Receipt
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$$\left(\begin{array}{|c|} \hline \\ \hline \end{array} \right) \begin{array}{|c|} \hline \\ \hline \end{array} - \begin{array}{|c|} \hline \\ \hline \end{array}$$

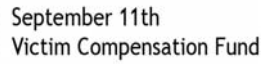
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[illegible]

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A diagram showing a 2x2 grid of squares, followed by a slash, another 2x2 grid, another slash, and a 1x4 grid of four squares.

$$\left(\begin{array}{|c|c|c|} \hline & & \\ \hline \end{array} \right) \begin{array}{|c|c|c|} \hline & & \\ \hline \end{array} - \begin{array}{|c|c|c|c|} \hline & & & \\ \hline \end{array}$$

Three tens rods minus two tens rods equals one ten rod.

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